

§ 152.21

any pre-existing condition exclusions (as defined in § 152.2) with respect to such coverage.

(b) *Waiting periods.* A PCIP may not impose a waiting period with respect to the coverage of services after the effective date of enrollment.

§ 152.21 Premiums and cost-sharing.

(a) *Limitation on enrollee premiums.* (1) The premiums charged under the PCIP may not exceed 100 percent of the premium for the applicable standard risk rate that would apply to the coverage offered in the State or States. The PCIP shall determine a standard risk rate by considering the premium rates charged for similar benefits and cost-sharing by other insurers offering health insurance coverage to individuals in the applicable State or States. The standard risk rate shall be established using reasonable actuarial techniques, that are approved by the Secretary, and that reflect anticipated experience and expenses. A PCIP may not use other methods of determining the standard rate, except with the approval of the Secretary.

(2) Premiums charged to enrollees in the PCIP may vary on the basis of age by a factor not greater than 4 to 1.

(b) *Limitation on enrollee costs.* (1) The PCIP's average share of the total allowed costs of the PCIP benefits must be at least 65 percent of such costs.

(2) The out-of-pocket limit of coverage for cost-sharing for covered services under the PCIP may not be greater than the applicable amount described in section 223(c)(2) of the Internal Revenue code of 1986 for the year involved. If the plan uses a network of providers, this limit may be applied only for in-network providers, consistent with the terms of PCIP benefit package.

§ 152.22 Access to services.

(a) *General rule.* A PCIP may specify the networks of providers from whom enrollees may obtain plan services. The PCIP must demonstrate to HHS that it has a sufficient number and range of providers to ensure that all covered services are reasonably available and accessible to its enrollees.

(b) *Emergency services.* In the case of emergency services, such services must be covered out of network if:

(1) The enrollee had a reasonable concern that failure to obtain immediate treatment could present a serious risk to his or her life or health; and

(2) The services were required to assess whether a condition requiring immediate treatment exists, or to provide such immediate treatment where warranted.

45 CFR Subtitle A (10–1–12 Edition)

Subpart E—Oversight

§ 152.26 Appeals procedures.

(a) *General.* A PCIP shall establish and maintain procedures for individuals to appeal eligibility and coverage determinations.

(b) *Minimum requirements.* The appeals procedure must, at a minimum, provide:

(1) A potential enrollee with the right to a timely redetermination by the PCIP or its designee of a determination regarding PCIP eligibility, including a determination of whether the individual is a citizen or national of the United States, or is lawfully present in the United States.

(2) An enrollee with the right to a timely redetermination by the PCIP or its designee of a determination regarding the coverage of a service or the amount paid by the PCIP for a service.

(3) An enrollee with the right to a timely reconsideration of a redetermination made under paragraph (b)(2) of this section by an entity independent of the PCIP.

§ 152.27 Fraud, waste, and abuse.

(a) *Procedures.* The PCIP shall develop, implement, and execute operating procedures to prevent, detect, recover (when applicable or allowable), and promptly report to HHS incidences of waste, fraud, and abuse, and to appropriate law enforcement authorities instances of fraud. Such procedures shall include identifying situations in which enrollees or potential enrollees (or their family members) are employed, and may have, or have had, access to other coverage such as group health coverage, but were discouraged from enrolling.

(b) *Cooperation.* The PCIP shall cooperate with Federal law enforcement and oversight authorities in cases involving waste, fraud and abuse, and

shall report to appropriate authorities situations in which enrollment in other coverage may have been discouraged.

§ 152.28 Preventing insurer dumping.

(a) *General rule.* If it is determined based on the procedures and criteria set forth in paragraph (b) of this section that a health insurance issuer or group health plan has discouraged an individual from remaining enrolled in coverage offered by such issuer or health plan based on the individual's health status, if the individual subsequently enrolls in a PCIP under this part, the issuer or health plan will be responsible for any medical expenses incurred by the PCIP with respect to the individual.

(b) *Procedures and criteria for a determination of dumping.* A PCIP shall establish procedures to identify and report to HHS instances in which health insurance issuers or employer-based group health plans are discouraging high-risk individuals from remaining enrolled in their current coverage in instances in which such individuals subsequently are eligible to enroll in the qualified high risk pool. Such procedures shall include methods to identify the following circumstances, either through the PCIP enrollment application form or other vehicles:

(1) Situations where an enrollee or potential enrollee had prior coverage obtained through a group health plan or issuer, and the individual was provided financial consideration or other rewards for disenrolling from their coverage, or disincentives for remaining enrolled.

(2) Situations where enrollees or potential enrollees had prior coverage obtained directly from an issuer or a group health plan and either of the following occurred:

(i) The premium for the prior coverage was increased to an amount that exceeded the premium required by the PCIP (adjusted based on the age factors applied to the prior coverage), and this increase was not otherwise explained;

(ii) The health plan, issuer or employer otherwise provided money or other financial consideration to disenroll from coverage, or disincentive to remain enrolled in such coverage. Such considerations include pay-

ment of the PCIP premium for an enrollee or potential enrollee.

(c) *Remedies.* If the Secretary determines, based on the criteria in paragraph (b) of this section, that the rule in paragraph (a) of this section applies, an issuer or a group health plan will be billed for the medical expenses incurred by the PCIP. The issuer or group health plan also will be referred to appropriate Federal and State authorities for other enforcement actions that may be warranted based on the behavior at issue.

(d) *Other.* Nothing in this section may be construed as constituting exclusive remedies for violations of this section or as preventing States from applying or enforcing this section or other provisions of law with respect to health insurance issuers.

Subpart F—Funding

§ 152.32 Use of funds.

(a) *Limitation on use of funding.* All funds awarded through the contracts established under this program must be used exclusively to pay allowable claims and administrative costs incurred in the development and operation of the PCIP that are in excess of the amounts of premiums collected from individuals enrolled in the program.

(b) *Limitation on administrative expenses.* No more than 10 percent of available funds shall be used for administrative expenses over the life of the contract with the PCIP, absent approval from HHS.

§ 152.33 Initial allocation of funds.

HHS will establish an initial ceiling for the amount of the \$5 billion in Federal funds allocated for PCIPs in each State using a methodology consistent with that used to established allocations under the Children's Health Insurance Program, as set forth under 42 CFR Part 457, Subpart F, Payment to States.

§ 152.34 Reallocation of funds.

If HHS determines, based on actual and projected enrollment and claims experience, that the PCIP in a given State will not make use of the total estimated funding allocated to that